

Peterborough City Hospital Final report

LAP Assessment Report ID : LAP-01163

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Peterborough City Hospital Final report

Location findings

Ratings for this location

Overall	Requires improvement	
Safe	Requires improvement	
Effective	Requires improvement	
Responsive	Requires improvement	
Well-led	Good	

Overall location summary

The North West Anglia NHS Foundation Trust (NWA NHS FT) was formed on 1 April 2017 when Peterborough and Stamford NHS Foundation Trust merged Hinchingsbrooke Health Care NHS Trust on 1 April 2017. The Trust provides a range of acute NHS hospital services across three sites, as well as Community Clinics at Doddington, Ely and Wisbech. They provide care for 850,000 people living in Peterborough, North and East Cambridgeshire, Huntingdonshire, South Lincolnshire, East Leicestershire, Rutland, Bedfordshire and East Northamptonshire.

We carried out an assessment of urgent and emergency care (UEC), and medical care services at Peterborough City Hospital. The assessment commenced on 26 June 2024, and included an unannounced visit to UEC and the medical service by a team of inspectors and specialist advisors on 30 and 31 July 2024. The assessment focussed on a number of quality statements under the Safe, Effective, Responsive, and Well Led domains. Following the assessment, the UEC service h....

Safe

Rating Requires improvement 

Our overall rating of safe at Peterborough City Hospital remains requires improvement.

Peterborough City Hospital

Location findings

We looked at UEC and medical services. We rated safe as requires improvement for UEC. We rated safe as requires improvement for medical services.

Effective

Rating Requires improvement 

Our overall rating of effective at Peterborough City Hospital remains requires improvement. We looked at UEC and medical services. We rated effective as good for UEC. We rated effective as good for medical services.

Responsive

Rating Requires improvement 

Our overall rating of responsive at Peterborough City Hospital remains requires improvement. We looked at UEC and medical services. We rated responsive as requires improvement for UEC. We rated responsive as good for medical services.

Well-led

Rating Good 

Our overall rating of well led at Peterborough City Hospital is good. We rated well led as good for UEC. We rated well led as good for medical services.

Medical care (Including older people's care)

Overall	Good	
Safe	Requires improvement	
Effective	Good	
Responsive	Good	
Well-led	Good	

Our view of the service

The North West Anglia NHS Foundation Trust (NWA NHS FT) was formed on 1 April 2017 when Peterborough and Stamford NHS Foundation Trust merged with Hinchingsbrooke Health Care NHS Trust on 1 April 2017. The Trust provides acute hospital services across three sites, as well as Community Clinics at Doddington, Ely and Wisbech. They provide care for 850,000 people living in Peterborough, North and East Cambridgeshire, Huntingdonshire, South Lincolnshire, East Leicestershire, Rutland, Bedfordshire and East Northamptonshire. The medical care services (including older people's care) at Peterborough City Hospital have 410 medical inpatient beds located across 15 wards and units, including an endoscopy service. We carried out an assessment of medical care services following information of concern around access and flow, delayed discharges, staffing shortages, and culture. The assessment commenced on 26 June 2024, and included an unannounced visit to the medical service by a team of inspectors and specialist advisors on 30 and 31 July 2024. We inspected 13 quality statements across the safe, effective, responsive and well-led key questions and have combined the scores for these areas with scores from the last inspection to give the rating. Following the assessment, the service remains with an overall rating of good, with requires improvement for safe. We found two breaches of regulations relating to safe care and treatment and staffing. The needs of patients admitted to escalation areas and patients cared for in the corridor were not always met. Staff did not always follow boarding criteria and in-patient boarding was not always in line with policy. Oxygen cylinders were not always properly secured. Not all patients who received

Medical care (Including older people's care)

oxygen from a cylinder had individual risk assessments completed for this use. Staffing levels did not always meet planned levels. Compliance with training did not always meet the recommended target.

People's experience of the service

People we spoke with during our assessment told us risks were explained by staff and they mostly felt involved in decision making. They told us they knew who to contact during their care journey. Comments included “The procedure was not explained on the ward, but now I have asked questions and now come to a more informed decision”.

Some patients we spoke with told us they were not always informed of their planned care and treatment. We heard comments, such as, “We get mixed messages regarding which scans have been carried out and whether he needs a drip or not”.

Patients knew who to contact if they required support, and follow up arrangements were made prior to discharge.

People were confident about raising concerns and they said staff responded quickly.

Most patients we spoke with on assessment told us that they had access to meals and drinks when required, and that their nutrition and hydration needs were met. However, some patients we spoke with, particularly those cared for in in-patient boarded spaces (delivering care in areas not designed for clinical use), told us that they did not have access to meals that were specific to their dietary requirements.

People could access care, treatment, and support when they needed it, including out of hours and in an emergency. Most patients told us they were regularly updated automatically by staff on care and treatment. They, along with their families, were able to discuss possible treatment.

People did not experience discrimination or inequality. Most people with additional needs did not feel they were disadvantaged. The service made reasonable adjustments for people with disabilities, those with communication difficulties or cognitive impairment.

Safe

Rating Requires improvement



Medical care (Including older people's care)

At our last assessment we rated this key question requires improvement. At this assessment, the rating remained the same. The service was in breach of the legal regulations relating to safe care and treatment and staffing.

There was a culture of safety and learning. Risks were dealt with willingly as an opportunity to put things right, learn and improve. Staff felt confident to raise concerns, however, they did not always feel listened to. Incidents were appropriately investigated.

Safety and continuity of care was a priority throughout people's care journey. There were systems and processes in place to ensure safety, although staff did not always complete all processes, and sometimes patients were not reviewed as needed.

People using the service were informed about any risks and how to keep themselves safe. Risks were assessed, and people and staff understood them. Risk assessments about care were person-centred, proportionate, and regularly reviewed.

Most people were cared for in a safe environment that was designed to meet their needs. However, the care of patients in boarding beds (cared for in corridors) and escalation areas did not always follow the trust's policies and procedures to ensure this was safe.

Recruitment practices were safe. Compliance with training mostly met the recommended target, although there were some shortfalls. Staffing levels did not always meet planned levels. However, three times a day staffing reviews and the use of an acuity tool ensured staffing concerns were escalated and mitigations put in place to reduce risk. Staff received training that was relevant to their roles and responsibilities, and support they needed to deliver safe care.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

People we spoke with during our assessment told us risks were explained by staff and they mostly felt involved in decision making, although there were sometimes differing views on

Medical care (Including older people's care)

explanations being given sufficiently ahead of procedures. They told us they knew who to contact during their care journey. Patient comments included “The procedure was not explained on the ward, but now I have asked questions and now come to a more informed decision”, and “I was informed of the care and treatment I would receive on arrival to the unit. A leaflet came in the post of what to expect but this was in English and I am unable to read it”.

One patient felt their plan of care could be improved due to difficulty in discussing whilst in a boarding bed.

People were confident about raising concerns and they said staff responded quickly.

As part of the assessment, we reviewed 3 complaints the trust had received. The service had recognised themes from complaints, including, but not limited to, clinical decision making and poor care.

Feedback from staff and leaders

A system was in place to investigate incidents and identify learning. Incidents were reviewed daily and involved a collaborative approach, between management and ward teams. Incidents requiring immediate attention were investigated as a priority, to ensure potential safety concerns were addressed and mitigated.

Monthly governance meetings were held to discuss incidents, identify themes and learning, and action to reduce future occurrence.

Staff we spoke with during the assessment felt confident to report incidents in line with trust policy. Most staff were able to discuss how incidents were reported and how they were fed back to staff. They were able to give examples of a variety of methods used by leaders to share feedback from incidents and identified shared learning such as safety alerts, team meetings, emails and posters. However, not all staff were confident their concerns were listened to or acted on, nor did they always receive feedback.

Staff told us they were able to raise concerns through a variety of avenues, including freedom to speak up guardian (FTSUG) and knew how to contact them.

Processes

Staff had systems to raise concerns both formally and informally. A Patient Safety Incident Response Framework (PSIRF) policy was in place, which set out the trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. A Patient Safety Incident Response Plan was also in place, which set out how the trust sought to learn from patient safety incidents reported by staff, patients, their families and carers as part of their work to continually improve the quality and safety of care provided.

Reports were analysed and urgent actions taken by leaders to manage or remove risks. Incidents were appropriately investigated. We reviewed the last 3 completed investigations relating to a safety incident within medical care. We saw that the service undertook thorough investigations and identified opportunities for learning with an aim to minimise similar incidents recurring in the future.

A Duty of Candour Policy was in place, which set out staff roles and responsibilities regarding openness, honesty and transparency if something went wrong with a patient's care or treatment.

A Complaints Policy was in place and complaints were appropriately investigated, although there were sometimes a delay in responding to complaints in line with the trust's guidance. We reviewed 3 complaint responses within medical care, which all identified opportunities for learning. Learning from complaints was shared with staff through a number of different methods, including a quarterly newsletter. The main themes from complaints in the latest quarter related to communication and medical/clinical care.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

Not all patients or relatives we spoke with told us they were informed of their planned care and treatment. We heard comments, such as, “We get mixed messages regarding which scans have been carried out and whether he needs a drip or not”, and “I felt a bit rushed to sign the consent form, but have managed to speak to a consultant now who has explained it all to me”.

Patients knew who to contact if they required support, and follow up arrangements were made prior to discharge. One patient told us the results of their investigation and follow up review was communicated to them before leaving with a discharge letter. Another patient on the ward said, “I see the doctors regularly and I know what the plan is”.

Some patients told us that they had discussed their wishes regarding how much care they wanted, should they deteriorate during their admission, and this was documented in their notes to reflect their decision.

Feedback from staff and leaders

Safety and continuity of care was a priority, and there was a strong awareness of risks to people. Risk assessments were completed by staff, including but not limited to, falls, pressure ulcers and safeguarding. We reviewed care records for 10 patients. There was evidence of evaluation of risk at each contact through their care journey, with clear documentation of risk that was acted upon.

Staff identified deteriorating patients through the use of tools such as the national early warning score (NEWS). Staff confirmed there was a process for escalating deteriorating patients to the critical care outreach team (CCOT) through an adverse NEWS score, which could be seen hospital-wide on the electronic system. Patients could also be placed on ‘Amber’ care, which was a way of alerting the palliative care and CCOT to unwell patients. The service had developed an overnight ‘hospital at night’ team that pro-actively oversaw the electronic system

Medical care (Including older people's care)

and contacted ward staff to check on patients' condition if they felt there was any deterioration.

Staff attended a daily MDT handover where all patients' care and treatment was discussed. Staff took part in meetings that were proactive in identifying when patients were to be discharged, although not all areas made the most of this opportunity to plan for discharge as early as possible. Ward-based therapists did not attend the MDT meetings we observed and there were numerous nursing actions that had not been completed.

Staff used a 'situation, background, assessment and recommendation (SBAR) format to provide updates during staff handover and when transferring patients to other areas and shifts.

Feedback from Partners

Senior leaders had developed a set of Internal Professional Standards to ensure patient flow, timely decision making and safe patient care. These provided guidance about the optimum discharge of patients. However, audits for these standards were not completed.

Processes

Audits to monitor compliance and performance of systems and process for patient assessment were completed. Overall compliance was good or improving. For example, staff had completed over 95% of venous thromboembolism (VTE) risk assessments and training in falls prevention was above 96%. The number of falls and hospital acquired pressure ulcers had also fallen. Completion of national early warning score (NEWS2) records was lower at 78% in July 2024. However, the audits had shown a consistent improvement since the NEWS2 audit in July 2023, which was 59%. The trust had undertaken a quality improvement project to drive improvement in the completion of NEWS2, which had identified reasons for the low completion rate and identified actions to improve completion.

Policies were in place to support staff plan and deliver appropriate care, according to best practice and national guidance. We reviewed policies for deteriorating patients, those with possible sepsis and the opening of non-inpatient escalation areas.

Medical care (Including older people's care)

However, although there was an in-date policy for the opening of escalation areas, staff did not always adhere to the inclusion/exclusion criteria. Incident reports for the endoscopy escalation area indicated patients transferred to this area did not always have their discharge arranged, were not always the same sex, more patients accommodated in the escalation area than agreed in the policy, patients in the area for multiple days, and patients with conditions that were in the exclusion criteria for non in-patient escalation. Incidents for in-patient boarding also identified that staff did not always follow boarding criteria when transferring patients.

Policies were in place for the safe use of oxygen administered from a cylinder, which was mostly adhered to. However, we did see oxygen cylinders that were not properly secured. Not all patients who received oxygen from a cylinder had individual risk assessments completed for this use.

Safeguarding

Score

3. Evidence shows a good standard of care

People's Experience

All patients we spoke with during assessment told us they felt safe and comfortable to raise concerns.

Feedback from staff and leaders

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team that staff could access when they had concerns. We reviewed care records and saw evidence of safeguarding concerns being raised by staff with appropriate escalation and action taken to safeguard vulnerable adults.

Staff reported completing safeguarding training and were alerted to updates by email. They told us they could refer and review safeguarding referrals on the trust's electronic system.

Processes

Medical care (Including older people's care)

Safeguarding policies and procedures were in place. We saw how the service's safeguarding process worked in practice on one ward where there were concerns about a patient's care in the community. This was completed in line with the trust's process and staff confirmed the safeguarding lead had been made aware of the referral.

Overall safeguarding training compliance for nursing staff was 94%, against a trust target of 90%. Overall safeguarding training compliance for medical staff was 83%, against a Trust target of 90%. Compliance with Safeguarding Training level 3 for medical staff was particularly low at 69%.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

Patients reported feeling supported and cared for by both the nursing and medical teams. They also acknowledged that staff were not happy that they were caring for patients in the corridor. Two patients cared for in corridor beds told us their needs were not always being met by being in these beds. One patient in a fit to sit chair in a 4-chair area said they felt very isolated. Patients reported being moved from the corridor into a treatment room overnight because of noisy equipment they were using, or not being able to sleep in the corridor due to the lights and noise.

Feedback from staff and leaders

Policies and procedures were in place for patients cared for in the corridor.

Staff told us who was responsible for flushing little used water outlets each week and the action they took if this was not carried out to help reduce the risk of bacteria build up.

There was variable understanding of ligature risks amongst staff, with one staff member unaware of any ward risk assessments. Another staff member confirmed that patient risk

Medical care (Including older people's care)

assessments were completed as part of the falls risk assessment. This staff member also confirmed that call bells were not easy release, but staff had been alerted to a ligature incident due to the persistent call bell ringing. However, reliance on this to alert staff was not without risk, particularly in a busy area as it may not ensure staff are able to attend the patient in sufficient time to prevent injury.

Observation

The design of the environment in specialist areas, such as endoscopy, followed national guidance.

Staff completed safety checks of specialist and emergency equipment and we saw adult resuscitation equipment was checked daily. Staff also completed safety checklists in specialist areas, such as endoscopy, to ensure that equipment and areas were clean and safe for patients and staff.

Call bells were accessible to patients if they needed support. Patients cared for in the corridors had a portable call bell which alerted staff with a doorbell sound. However, staff did not always respond quickly when call bells were used; we saw a call bell not answered for 6 minutes. We saw occasions where in-patient boarding beds obstructed access for portering staff and a lack of space on wards led to medical staff having private and sensitive conversations with patients in corridors, which could be overheard. There were no storage facilities for in-patient boarding patients to safely store their belongings or own medicines. We saw corridor care was not always in line with policy, for example for patients that were on oxygen and a lack of signage. The area in endoscopy where patients were boarded overnight did not always have same sex bed or toilet areas.

There were 14 'fit to sit' chairs used in the 24-hour stay medical admissions unit, but staff told us at the time of our visit the longest patient stay in a fit to sit chair was 48 hours due to the inability to move to a bed.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

During our previous inspection in 2022, we found that the service had not ensured the National Patient Safety Alerts were actioned specific to airflow meters. During this assessment we found

Medical care (Including older people's care)

that this had been actioned and no air flow meters were on wards.

Processes

During our onsite assessment, we checked 10 pieces of equipment for service dates and found all were in date for testing. We saw staff had identified and clearly labelled faulty equipment and arranged for this to be collected from wards.

We reviewed emergency trolleys for compliance with daily/weekly checks in line with trust policy. We found a good compliance across the wards with accurate records of checks with no gaps in daily check list records for the emergency trolley.

Staff told us they could access trust policies and standard operating procedures online to ensure they were delivering safe care in line with policy and were made aware of updates policies via email and at team meetings.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

Most patients we spoke with felt there were enough staff and they received care and support when this was needed. Patients reported, "There is always someone at the nursing station if I need them", "I sometimes have to wait a while to get help" and "All staff are very caring and sympathetic."

Feedback from staff and leaders

Staffing levels did not always meet planned levels in all areas. Staff told us that sometimes there were not enough staff to support at meals times and they were not given extra staff to manage additional boarded patients. We were told patients had to wait until staff were available for meal support and, although understaffing was escalated, routinely there was no

Medical care (Including older people's care)

replacement or increase in resources or bank staff availability. Staff felt that at times the acuity of patients meant that they could not always meet the demands placed on them in a timely manner. Although, they had volunteers that visited the ward to support patients during their admission.

Staff told us they received training that was relevant to their roles and responsibilities. As well as mandatory training, staff received specialty specific training as well as learning identified through incidents. Staff were rostered according to the competency/training they required which they felt worked well. We saw packs that staff received detailing the training they were required to complete with oversight from managers and practice development nurses. They knew when to complete required training and received reminders from their managers. Staff told us they received appraisals annually and were encouraged to identify additional learning and development.

Both medical and nursing staff from overseas said they were happy and felt supported. They were able to raise concerns with educational supervisors and clinical leads and felt supported in dealing with issues.

Observation

During our visit, we saw that nursing staffing numbers were lower than planned in some areas. Managers looked at the acuity in each area and moved staff to where they were most needed to ensure staffing was safe.

Processes

The mandatory training programme was in line with Skills for Health's Core Skills Training Framework (England). Most nursing and medical staff were up to date overall on mandatory training, with 89% completion against a trust target of 90%. However, completion rates for some elements, such as advanced life support, had particularly low completion rates below 66%. Systems were in place to support staff through supervision and annual appraisals. Overall, 87% of nursing staff and 95% of medical staff had received an appraisal within the 12 months to 30 June 2024. A practice development team and specialist nurses were also available for staff support. Staff used a recognised tool to assess patients' acuity and dependency, where each patient's care hours were calculated to support the need for additional staff if required. The policy also provided guidance for safe staffing of escalation areas and boarding patients.

Medical care (Including older people's care)

Monthly and bi-annual analysis of staffing levels, sickness, recruitment and retention, and turnover rates were completed, and compared against ICB and national provider information. When compared to other Trusts within the Integrated Care Service, the trust consistently recorded a lower turnover rate. Overall, the service had enough nursing and medical staff to keep patients safe, although some specific areas did not have a full complement of permanently employed staff. Senior staff were guided by the trust's recruitment, safer staffing and capacity escalation policies, which ensured additional staff could be sought when there were not enough permanently employed staff available. The service showed consistent use of bank and agency staff, although data provided showed in July 2024, there were an average of 6.5 nursing shifts not covered each day. Vacancy rates for nursing and medical staff were low at 3% and 2%, absence rates for medical staff were also low at 3%, which was below the trust target of 3.5%. Nursing absence was slightly higher than the trust target at 4%.

Infection prevention and control

Score

3. Evidence shows a good standard of care

People's Experience

Most patients we spoke with told us the ward areas were clean. All patients we spoke with told us that they saw staff washing their hands and using aprons and gloves.

Feedback from staff and leaders

There were clear process and systems in place to manage the risk of infection. Staff explained the approach to assessing and managing the risk of known infection, such as Hepatitis B. Clear signage indicating infection was used with machine decontamination protocols in place. Staff told us processes were in place for checking patient lists for known infection and checking recent blood test results. We saw documentation to support the daily checks had taken place.

Staff told us they knew who was responsible for cleaning different areas within the wards and units, and which pieces of equipment. All areas of the service we visited were visibly clean, cleaning staff explained their schedules, which included the areas they were allocated to clean

Medical care (Including older people's care)

daily. They told us there were cleaning staff present every day and evening and an on-call cleaner was available overnight.

Observation

All ward and department areas were visibly clean with suitable furnishings that were clean and well maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection prevention and control principles such as, bare below the elbows, and we observed staff don and doff aprons and gloves before and after entering side rooms isolating infectious patients. Hand gel was available for staff and visitors within ward areas. Patients with potentially infectious illnesses were isolated in single rooms which were clearly signposted to staff and other patients.

Quality Balanced Scorecard results with performance relating to infection, prevention and control audits, such as the number of MRSA infections and hand gel compliance were displayed for each ward area for staff, patients and visitors to see. We saw green RAG ratings for performance in the last 3 months indicating good compliance against trust targets. Cleaning scores displayed in ward areas showed most areas consistently performed well for cleanliness. Where there were exceptions, the service implemented a cleaning action plan to address identified concerns.

Processes

Data showed hand hygiene audits were completed monthly in most areas, although there were some areas that routinely did not complete this audit. Most areas regularly achieved scores of 100% compliance each month. Where staff had identified issues, these had improved on the following audit. Infection, prevention and control audits similarly identified where there were issues, although not all audits recorded specific information or any immediate actions that had been taken to improve.

Leaders monitored the rates of hospital-based infections, such as common transmissible bacteria, such as E Coli, MRSA or Clostridium Difficile. Audits and monitoring systems showed there had been an overall improvement in actions, such as hand hygiene and dress code, to

Medical care (Including older people's care)

reduce the risk of cross infection. Actions, such as MRSA suppression therapy and monitoring of catheters and intravenous cannulas meant low or no hospital acquired infections in the 3 months before our visit. However, incidents of other infections, such as clostridium difficile, remained above the trust target.

The trust had a policy to guide staff in the management of infectious respiratory infections. There were clear instructions for cohorting patients and when this should be considered, which did not include patients that did not have the same infectious agent.

Effective

Rating Good 

Patients received care, treatment and support that was evidence-based and in line with good practice standards. Systems in place ensured staff were up to date with national legislation, and evidence-based good practice. Staff and leaders were encouraged to learn about new and innovative approaches to improve the way care was delivered.

However, patients' nutrition and hydration needs were not always met. Three patients we spoke with told us they did not have access to meals that were specific to their dietary requirements, or that they did not receive the meal they had requested.

Delivering evidence-based care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

Staff did not always meet people's nutrition and hydration needs. Most patients we spoke with on assessment told us that they had access to meals and drinks when required, and that their nutrition and hydration needs were met. However, some patients we spoke with, particularly those cared for in the corridor, told us that they did not have access to meals that were specific

Medical care (Including older people's care)

to their dietary requirements, and another told us they did not receive a meal as it had not been requested by the ward. We spoke with one boarding patient who was not aware and had not been informed that their lunch had been placed on a table. He told us he required assistance to open the sandwich, but support for this was not offered. An inpatient on the stroke ward told us that staff were not always available to support in cutting up food at meal times.

Staff gave people information about their care and treatment needed to support both their physical and mental health. A patient told us they were given verbal and written information on how to manage their diabetes and weight in order to reduce further complications in health.

Feedback from staff and leaders

Staff told us that mealtimes were protected and that they supported patients with meals as required. However, staff felt that, at times, low staffing impacted on their ability to assist multiple patients with meals. We spoke with a catering hostess who told us that they would ring a patient's call bell if they required support with meals and if meals had not been eaten, they would not be cleared so that staff were aware.

Staff told us that meals for patients cared for in corridors would need to be requested directly and this was not recorded in line with the bedded patient's on the ward. This, at times, led to meals not being requested in time and patients having to wait for 1-2 hours for a hot meal. Staff did report that patients were able to request a snack box at any time which offered a sandwich, drink and fruit. However, it was acknowledged that this was not always suitable for patients on a modified diet.

Staff used effective tools for screening malnutrition and dehydration and acted on any indicators of concern. Staff told us that they completed the Malnutrition Universal Screening Tool (MUST) as part of the adult admission nursing assessment. Staff were able to discuss how and when they would complete a dietician referral.

Staff told us that they received training that was specific to the speciality of the ward aligned with good practice to deliver effective care. A nurse told us that the specialist nurses supported staff and patients during their admission ensuring care was in line with best practice.

Processes

Medical care (Including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a variety policies and guidelines and noted all were up to date. Staff used evidence-based, standardised risk assessment tools to identify the level of patient risk for areas such as pressure ulcers and nutrition level. Staff in medical care worked with staff from other areas of to improve outcomes for patients by reducing the endoscopy waiting list, increasing the number of patients discharged each day, and the introduction of virtual clinics for patients receiving treatment for irritable bowel disease.

There was a process in place to ensure that all adults had MUST action and prevention plans following admission.

Staff encouraged patients to drink and for one patient, we saw a staff member spending additional time to support them to drink orally to reduce their need for fluids through a PEG. Patients with difficulty eating were identified through a Red Tray system. However, boarded patients cared for in corridors had to have their food ordered directly with the kitchen. We did see instances where boarded patients either did not receive meals or received incorrect meals for their dietary needs.

Leaders encouraged innovation and participation in research. Staff in the service collaborated with regional trusts and technology providers to support the introduction of new practice. We received information about several examples of initiatives, innovations and quality improvement carried out in the service. This included participation in the use of a sub-epidermal moisture (SEM) scanner for early detection of tissue injury, which allowed staff to reconsider how they cared for the patient to reduce the risk of skin breakdown. The service was in the process of introducing digital technology to enable patients to see their own records, monitor conditions such as atrial fibrillation or improve fast detection of strokes.

Responsive

Rating Good 

There was not always continuity in people's care and treatment because services were not always flexible and joined-up. People's care and treatment was not always delivered in a way that met their needs as services were not always coordinated and responsive. However, people received care and treatment from services that understood the diverse health and social care needs of their local communities.

Medical care (Including older people's care)

People could mostly access care, treatment, and support when they needed it, including out of hours and in an emergency. Physical premises and equipment were accessible.

People did not experience discrimination and staff worked hard to provide equity in access to care and treatment. They made reasonable adjustments where required and listened to people's concerns to improve the service.

Care provision, integration and continuity

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

Some patients we spoke with did not always feel their care and treatment was delivered in a way that met their needs. For example, patients cared for in corridor beds told us their needs were not always being met by being in these beds, and that their care could be improved.

Feedback from staff and leaders

Medical staff told us that people's care and treatment was, at times, disjointed. Teams were felt to work in silo and that the system was not flexible enough to ensure it was as coordinated and responsive as it could be. For example, a lack of therapists based on wards impacted on the communication and continuity for patients, as well as delays in internal discharge processes. Staff reported delays in dispensing of discharge medicines and arranging inpatient tests, which impacted on patient flow through the hospital and delayed discharges.

Staff told us there were problems with the flow of patients through the hospital, particularly with some specialty teams, and that there was a lack of adherence to internal professional standards. They said this was one reason why beds in short stay units were not available. Some areas had strict admission criteria to reduce the risk of patients not being able to be transferred out when the unit closed. However, staff in these units told us they often finished late because patients were not able to be discharged or transferred.

Staff told us that some patients were not able to receive dialysis close to their homes due to a

Medical care (Including older people's care)

lack of capacity. This meant patients were travelling over 2 hours to receive treatment. Staff told us they ringfenced 4 slots in order to support flow by offering dialysis to patients that were not able to access care in their local area. At the time of our assessment, we were told there were 3 patients that were being treated further away from their homes due to local outpatient availability. The service was looking to increase their staffing to offer a Sunday service to support the increased demand.

We saw examples where different groups of staff supported patients to return to bed or to reduce their distress when nursing staff were not available. For example, physiotherapists putting patients back to bed, and managing a patient who was confused, behaving aggressively who wanted hot drink.

Processes

The service considered the needs and preferences of different people. For example, staff could access interpreters in advance of appointments to support patients who had language barriers in order to ensure that care was coordinated. Staff could also support patients that spoke their native language. The service sought feedback from service users from a variety of sources such as a comments book, surveys and QR codes that could be scanned to allow for feedback. Staff felt supported to make suggestions on improvements based on feedback given.

There were delays to flow through the hospital, which were mainly caused by social care and medication delays. Other causes included delays in echocardiogram referrals, and occasional delays with portering and phlebotomy services.

There were also delays in discharges. Recent bed occupancy at Peterborough City Hospital (PCH) had been higher than the national average. Since late-March, general and acute bed occupancy has been mostly 97-99% at PCH when escalation beds were included, compared to 92-94% nationally, but over 100% for PCHs regular bed base, compared to approximately 95-97% nationally.

Capacity, such as availability of residential/nursing home or rehabilitation, and availability of resources was consistently the main contributor leading to patients remaining in hospital when they no longer met the criteria to reside.

Discharge notifications were either not submitted until medically fit for discharge or submitted early but then rejected. Discharges were not always pre-empted the day before planned

Medical care (Including older people's care)

discharge (TTOs, discharge letter). Patients deemed medically fit were kept in hospital until test results were at a level acceptable by a clinician.

The service had a patient discharge lounge for use by patients waiting for transport or medicines before going home. Staff told us that the lounge was usually well used in the afternoon, but was quite often quiet in the mornings.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

People's Experience

People could generally access care, treatment, and support when they needed it, including out of hours and in an emergency. Most patients told us they were regularly updated automatically by staff on their care and treatment. They, along with their families, were able to discuss possible treatment.

People did not experience discrimination or inequality. Most people with additional needs did not feel they were disadvantaged. The service made reasonable adjustments for people with disabilities, those with communication difficulties or cognitive impairment. However, one patient reported being hard of hearing and that she felt she did not fully understand the medical plan.

People were listened to when they wanted to share their experience.

Feedback from staff and leaders

Staff worked hard to remove any barriers to access for patients. There was a strong culture to prevent discrimination and inequalities. The service worked closely with external organisations to identify barriers to patient experience and discuss improvements. Staff listened to people who had concerns or complaints and sought ways to improve the service.

Medical care (Including older people's care)

However, patients did not always receive care, treatment and support in a timely manner. Staff told us that there was no pathway for acute physicians on the short stay medical wards to refer to speciality teams, as well as delays in speciality reviews for patients. This meant there were potential delays in patients accessing the care and treatment they needed. We were told this had been raised with senior leaders prior to the assessment.

Patients who were placed in other areas to their responsible consultant were allocated to a specific medical team each morning to reduce the risk of not being reviewed. However, 9% of patients were moved more than 4 times during their stay, with 3 of the 9% (13) as frequently as 11 and 15 times in July 2024. Over 250 patients were moved between 10pm and 7am, which may not provide optimum opportunity for healing due to disturbed sleep for these and other patients.

Staff told us that structured board rounds were used to identify priority reviews of patients based on their clinical need. One nurse told us that ward rounds did not always occur at scheduled times which impacted on timely decision making. We observed a consultant arriving 40 minutes late and the nurse informed us that this occurred on a regular basis.

Processes

Systems in place to provide therapy staff and pharmacy support at weekends and out of normal working hours. However, these were reduced services; therapy staff worked at weekends on a voluntary rota and they also covered urgent and emergency care. Patients were seen on a priority basis, although only 40-50% of patients referred to the team after emergency care patients were usually seen. The medical care division had submitted a request to have 2 therapy teams working at weekends to improve this.

The trust worked with regional partners, such as the Integrated Care Board (ICB) and the voluntary care sector, to develop alternative avenues for patient care. These included looking at patients' length of stay, their flow through the hospital as part of the back on track programme, and whether these were in line with national targets. Three of the 8 medical wards looked at for length of stay did not meet their national targets, although 4 of the other 5 were ahead of their targets. The service had introduced a virtual ward programme as part of its work with the Integrated Care Board (ICB) across the East of England, which was estimated to have saved over 2,500 bed days and over £500,000. As part of its work with the voluntary care sector the trust introduced a single point of access for patients needing simple support and advice or

Medical care (Including older people's care)

bridging care.

The trust had a policy to guide staff when discharging patients that followed information and advice from the Department of Health, NHS Improvement and adult social care organisations. The policy included guidance for complex and delayed discharges. Despite actions taken by the trust to improve discharge pathways, there remained high numbers of patients waiting for discharge.

The service was in the process of introducing digital technology to enable patients to see their own records, monitor conditions such as atrial fibrillation or improve fast detection of strokes. The service was fully physically accessible throughout.

Well-led

Rating Good 

Leadership for medical care included a multi-disciplinary triumvirate consisting of a trust-wide divisional nursing director, clinical lead (divisional director), and operations director.

Leaders had the experience, capability and integrity to ensure the services' vision could be delivered. They were knowledgeable about issues and priorities for the quality of services and could access appropriate support and development in their role. Leaders told us they visited clinical areas every 1-2 weeks to provide staff with the opportunity to discuss concerns.

There were clear governance, management and accountability arrangements. Staff understood their role and responsibilities. Managers accounted for the actions, behaviours and performance of staff.

There were systems in place to manage current and future performance and risks to the quality of the service. There were arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information was used effectively to monitor and improve the quality of care.

Leaders implemented relevant quality frameworks, recognised standards and best practices to improve equity in experience and outcomes for people using services and tackle known inequalities.

Staff and leaders had a good understanding of how to make improvement happen. There were processes in place to ensure that learning happened when things went wrong. The service had strong

Medical care (Including older people's care)

external relationships to support improvement and innovation. Staff and leaders engaged with external work, including research, to embed evidence-based practice.

Shared direction and culture

Score

3. Evidence shows a good standard of care

Feedback from staff and leaders

International staff told us they liked the working culture at the hospital, we heard comments such as, “Other staff are very supportive”, “Very happy on ward” and “Staff are friendly.” A comment made by the winner of one ward’s ‘Star of the Month’ was, “Staff are really valued and recognised” and they provided an explanation of the values given to achieve the award. Other staff told us, “Love working in the team”.

Processes

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy to cover a 3-year period from 2022 to 2025. The vision and strategy were focused on 5 goals; delivering outstanding care and experience, recruiting, developing and retaining the workforce, being an anchor for the community, working with health and social care providers and delivering long term sustainability. These were aligned to local plans within the wider health economy. Leaders had considered their role within the ICS and the North Integrated Care Place Partnership (ICPP), and included this throughout their strategy.

The service had also developed an improvement plan to complement these 5 goals, which monitored actions implemented.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

Feedback from staff and leaders

The trust had an established leadership structure within the division of medicine. This included a divisional director, divisional operations director, and a divisional nursing director, who made up the divisional triumvirate. They were supported by the divisional leadership team comprising of the associate divisional director, deputy divisional operations director and the head of nursing. They were supported by divisional operational managers, clinical leads, matrons and lead nurses and ward managers.

Staff told us they felt respected, supported and valued, particularly by senior leaders. They said senior staff, such as matrons were visible and approachable.

Leaders of the service were able to describe the challenges that the service faced. They told us they had the experience and capability to ensure the service's vision could be delivered.

Senior managers told us they visited clinical areas as often as possible and completed walkabouts every 1 to 2 weeks to engage with staff. This gave staff the opportunity to make suggestions about what would work better for them. Staff told us senior managers were approachable, they felt listened to and senior staff supported them.

Processes

The trust's staff survey showed improvement in all areas asked about. In all but one of these areas medical care scored equal to or higher than the trust average. The service completed an action plan to address issues identified in the staff survey in June 2023, however only 8 of the 24 actions had been completed over a year after the survey and 3 were still RAG rated as red.

Freedom to speak up

Score

3. Evidence shows a good standard of care

Feedback from staff and leaders

All staff that we spoke with during the assessment felt confident to raise concerns and knew of the Freedom to Speak Up guardians. However, they did not all feel listened to. Staff escalated concerns regarding patients cared for in corridors that did not meet the criteria, but despite reporting, this continued to occur. Staff, therefore, did not feel confident that their concerns were always listened to.

Processes

The service had systems in place to engage with staff and guidance was provided on how to do this in the trust policy. There were staff and student information boards in clinical areas that provided contact details for Freedom to Speak Up Guardians and others where staff could get support

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

Feedback from staff and leaders

The service had a clearly defined governance structure that supported the flow of information from frontline staff to senior managers and the trust board. Specialty governance meetings reported to the Clinical Business Unit meetings, which reported to the Joint Division Quality Governance & Management Board Meeting, which ultimately had oversight from the Hospital Management Committee.

Medical care (Including older people's care)

Monthly Medicine Joint Quality Governance Board meetings were held. We reviewed the last 2 governance meeting minutes and saw that discussion areas included performance data, audits, training, risks, guidelines and complaints.

Leaders monitored key safety and performance metrics. They identified and escalated relevant risks and issues and identified actions to reduce their impact. An audit programme was in place to provide assurance of the quality and safety of the service. Local audits, such as clinical and compliance audits were undertaken.

The divisional triumvirate regularly attended meetings to look at risk and governance, incidents, training compliance, complaints, and guidelines. They confirmed oversight of all complaints and responses before these went to trust governance review. They also met with complainants to fully understand the concerns.

Processes

There were systems in place to manage current and future performance and risks to the quality of the service. Leaders monitored key safety and performance metrics. They identified and escalated relevant risks and issues, and identified actions to reduce their impact. Information was used to monitor and improve the quality of care.

The service had a risk register which reflected current risks within the service. All risks had dedicated owners, risk and effect, risk ratings from red to green, and control measures. The risk register was reviewed and updated at regular intervals. Issues relating to corridor care was documented as a high risk on the register.

Specialty and divisional governance meetings were held monthly, although not always well attended by the multi-disciplinary team and not all the meetings had enough members present to make decisions. Attendance for April and May 2024 showed only 2 people attended both meetings and only one of these was from the divisional leadership team. Discussion areas included, but were not limited to, performance data, audits, incidents, guidance, complaints, and risk.

A Risk Management Policy was in place which described the Trust's approach to the management of risk at all levels within the organisation.

Acute services

Medical care (Including older people's care)

Various policies and procedures were in place to cope with unexpected events. An Emergency Preparedness, Resilience & Response Strategic Framework was in place, which detailed the strategic arrangements and the activities undertaken within the Trust to support the emergency preparedness and business continuity agendas. Specific business continuity plans were in place for specific areas such as the renal and respiratory areas.

There were arrangements for the availability, integrity and confidentiality of data, records and data management systems.